OMB Position on concurrent use of cannabis and opiates

Medical Marijuana

The Oregon Medical Marijuana Program is administered by the Oregon Health Authority. The relevant Oregon Revised Statutes are 475.300 through 475.346 and the Oregon Administrative Rules are 333-0008-0000 through 333-008-0120. The Oregon Health Authority's website on the Oregon Medical Marijuana Program provides additional program information and contact information.

The Oregon Medical Board does not oversee or otherwise regulate the Oregon Medical Marijuana Program.

The Board does not currently have a rule or a policy position on prescribing opioids to patients with a medical marijuana card. While the Board's consultants have included the use of marijuana among the list of contraindications for long-term opioid use, the Board has not prohibited the concurrent use of these drugs.

Prescribing practices do come to the Board's attention, and every written complaint is investigated as required by statute. The Board does not discipline physicians solely based on certifying patients for the use of medical marijuana, prescribing opioids to a known medical marijuana patient, or creating treatment plans that include the concurrent use of opioids and medical marijuana. However, if an investigation into a complaint showed inappropriate practices or unprofessional conduct by any physician, the Board would take action for any violations of the Medical Practice Act that are found.

The Board will continue its attention to this evolving area of medicine. Any updated policies created by the Board will be available on our website. We appreciate the public interest in this important issue and its impact on the safety of Oregon patients.

Additional Resources

- ORS Chapter 475: Controlled Substances; Illegal Drug Cleanup; Paraphernalia; Precursors
- OAR 333-008-0000 through 333-008-0120: Medical Marijuana
- Oregon Medical Marijuana Program (Oregon Health Authority)

Prescribing cannabis for harm reduction
Mark Collen, Harm Reduction Journal 2012, 9:1
http://www.harmreductionjournal.com/content/9/1/1

Abstract
Neuropathic pain affects between 5% and 10% of the US population and can be refractory to treatment. Opioids may be recommended as a second-line pharmacotherapy but have risks including overdose and death. Cannabis has been shown to be effective for treating nerve pain without the risk of fatal poisoning. The author suggests that physicians who treat neuropathic pain with opioids should evaluate their patients for a trial of cannabis and prescribe it when appropriate prior to using opioids. This harm reduction strategy may reduce the morbidity and mortality rates associated with prescription pain medications.

Oregon
John A. Kitzhaber, MD, Governor

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August 1, 2012

Claudia K. Little, BSN, MPH
180 Logan Dr.
Ashland, OR 97520

Re: Pain Management and Medical Marijuana Use

Dear Ms. Little:

Thank you for contacting the Oregon Medical Board with your concerns regarding its position on prescribing opioids to known medical marijuana patients.

The Board does not currently have a rule or a policy position on prescribing opioids to patients with a medical marijuana card. While the Board's consultants have included the use of marijuana among the list of contraindications for long-term opioid use, the Board has not prohibited the concurrent use of these drugs.

Prescribing practices do come to the Board's attention, and every written complaint is investigated as required by statute. The Board does not discipline physicians solely based on certifying patients for the use of medical marijuana, prescribing opioids to a known medical marijuana patient, or creating treatment plans that include the concurrent use of opioids and medical marijuana. However, if an investigation into a complaint showed inappropriate practices or unprofessional conduct by any physician, the Board would take action for any violations of the Medical Practice Act that are found.

The Board will continue its attention to this evolving area of medicine. Any updated policies created by the Board are always available on our website at www.oregon.gov/OMB. We appreciate your interest in this important issue and its impact on the safety of Oregon patients.

Sincerely,

Kathleen Haley

Kathleen Haley
Executive Director

Cannabis as an Adjunct to or Substitute for Opiates in the Treatment of Chronic Pain Journal of Psychoactive Drugs Volume 44, Issue 2, 2012 DOI: 10.1080/02791072.2012.684624

Abstract

There is a growing body of evidence to support the use of medical cannabis as an adjunct to or substitute for prescription opiates in the treatment of chronic pain. When used in conjunction with opiates, cannabinoids lead to a greater cumulative relief of pain, resulting in a reduction in the use of opiates (and associated side-effects) by patients in a clinical setting. Additionally, cannabinoids can prevent the development of tolerance to and withdrawal from opiates, and can even rekindle opiate analgesia after a prior dosage has become ineffective. Novel research suggests that cannabis may be useful in the treatment of problematic substance use. These findings suggest that increasing safe access to medical cannabis may reduce the personal and social harms associated with addiction, particularly in relation to the growing problematic use of pharmaceutical opiates. Despite a lack of regulatory oversight by federal governments in North America, community-based medical cannabis dispensaries have proven successful at supplying patients with a safe source of cannabis within an environment conducive to healing, and may be

reducing the problematic use of pharmaceutical opiates and other potentially harmful substances in their communities.

From: The Role of Cannabis and Cannabinoids in Pain Management, Russo, E. Weiner's Pain Management, Seventh Edition, 2006; pp 823-843

Cannabinoid Interactions with Opiates and Endogenous Opioids

THC experimentally increases beta-endorphin levels (Wiegant, Sweep, & Nir, 1987). Depletion of endorphins has been measured in the cerebral spinal fluid of migraineurs durillg attacks (Fetles, Gawel, Kuzniak, & Edmeads, 1985) and theorelically contributes to migraine erfects such as hyperalgesia and photophobia. Early exposure to THC in rat pups boosted adult levels of betaendorphins in specific brain areas (Kumar el al., 1990). Mailleux and Vanderhaeghen (1 994) have also demonstrated that **THC** regulates substance P and enkephalin mRNA levels in the basal ganglia. Manzanares et al. (1998) have shown THC is able promote increases in betaendorphin in rats. Meng and his group demonstrated that THC is involved in an analgesic brainstem circuit in the rostra1 ventromedial medulla that interacts with opiate pathways (Meng, Manning, Martin, & Fields, 1998). Cichewicz and her group examined the enhancement of opioid antinociception by oral THC in rodents (Cichewicz, Martin, Smith, & Welch, 1999). **THC** (20 **mgkg)** preceding morphine rendered it significantly more analgesic with an ED,, dropping from 28.8 to 13.1 mgkg. For codeine. the ED,, dropped phenomenally from 139.9 to 5.9 mgkg, with enhancement also noted for oxymorphone, hydromorphone, methadone, diacetylmorphine (heroin), and meperidine. This THC enhancement was decreased by naloxone, but not by other opiate-blockers, suggesting **an** effect on p-opioid receptors. In a subsequent study, Cichewicz, Haller, and Welch (200 1) demonsuated that continued low doses of THC and morphine in mice produce no behavioral tolerance to the opioid, and that the combination circumvented the expected downregulation of opioid receptor protein in the mouse midbrain observed in tolerant animals. Extension of this work (Cichewicz & McCarthy, 2003) demonstrated that oral doses of THC with either morphine or codeine produced synergistic increases in analgesia. Perhaps the most exciting development

from this group surrounds the suggestion that THC blocks opiate withdrawal effects and prevents the development of opiate tolerance (Cichewicz & Welch, 2003). Such tolerance **in** chronic opioid-treated mice was circumvented with nonanalgetic doses of oral THC, while THC also significantly reduced naloxone-precipitated withdrawal effects in such mice. Substantiation is thus provided for 19th century claims of utility of cannabis in treatment of opiate addiction, suggesting a new indication for clinical Finally. Cichewicz presented findings indicating that late administration of THC will restore opioid analgesic effects after low doses or ones that had previously worn off (Cichewicz, Rubo, & Welch, 2003), thus scientifically verifying the anecdotal reports of cannabis-opiate alternation from the 19th century. Welch and Eads (1 999) note cannabinoid-induced analgesia produced antinociception through spinal dynorphin release with synergistic effects with opiates. They state, however, 'THC, in cornparison to the morphine derivatives, has a greater therapeutic range" (p. 188). Many analgesic effects of cannabinoids cannot be reproduced by opiates, however, particularly in cases of neuropathic pain (Hamann & di Vadi, 1999). Nicolodi (1998) examined opiate aggravation of migraine. Manzanares (Manzanares et al., 1999) cited that chronic cannabinoid administration could similarly promote hypothalamic production of beta-endorphin. Strangman and Walker (1999) demonstrated that a cannabinoid antagonist was able to decrease wind-up in spinal nociceptive neurons producing hyperalgesia and allodynia in chronic pain states. **A** similar group (Walker et al., 1999) showed that cannabinoids selectively affect nociceptive neurons in the spinal cord and ventroposterolateral nucleus of the thalamus in a manner that promotes antinociception without anesthesia. In all, seven sites in the CNS involved in pain processing produced effects after microinjections of cannabinoids, effecting a circuit that mediates the descending pain suppressing effects of opiates.